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PROMOTE PROTECT PROSPER

SC ADAP INSURANCE ANNUAL RECERTIFICATION

Return To:
Patti Sullivan, 3rd Floor, Mills/Jarrett
Box 101106
Columbia, SC 29211
(803) 898-0214 or (877) 606-8498

FOR ADAP USE ONLY - DO NOT WRITE IN THIS SPACE

Date Rec'd: _____ Status: _____

Status/Date: _____

PATIENT INFORMATION: To be completed by Applicant (Please print)

Name: _____
Last First Full Middle Name

Home Address: _____ City: _____ State: _____

Zip: _____ County: _____ Phone (H): (____) _____ (W): (____) _____

Mailing Address: _____ City: _____ Zip: _____

Birth Date: Mon _____ Day _____ Year _____ Sex: _____ Weight: _____ Social Security #: _____/_____/_____

Ethnicity (check one): ☐ Hispanic/Latino(a) ☐ Non-Hispanic /Latino(a) **Race (check all that apply):** ☐ White ☐ Black

☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native ☐ Unknown ☐ Other _____

SOCIAL AND FINANCIAL DATA

Applicant and Other Members in Household	Relationship To Applicant	Sex	DOB	Place of Employment or Source of Other Income	Estimated **Yearly** Gross Income
Applicant					

ASSETS (list only if applying for Insurance Continuation):

Cash/Savings $ _____ Stocks/Bonds $ _____

Severance Pay $ _____ Mutual Funds $ _____

Funds for this program come from Federal HRSA, Title II and State programs and are for low-income persons. This program is the payor of last resort. Persons with Medicaid cannot qualify for this program.

CURRENT PHYSICIAN: _____ **CURRENT CASE MANAGER:** _____

Are you currently approved for Medicaid? ☐ Yes ☐ No **Application pending?** ☐ Yes ☐ No

Are you currently approved for Medicare? ☐ Yes ☐ No **Are you eligible for Medicare?** ☐ Yes ☐ No

Do you have insurance coverage for prescriptions? ☐ Yes ☐ No

CERTIFICATION/CONSENT: I certify that the information provided in this application is true and correct to the best of my knowledge. I give permission to ADAP to verify this information, either through written documentation or electronic files. I agree to notify ADAP of any changes to my income or Medicaid/insurance status within 30 days. I will inform ADAP if my address changes or if I choose not to participate in the program. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship. **I also understand the importance of taking medications as prescribed and that failure to do so may result in my being automatically dropped from the program after 90 days.** ***By my signature, I authorize the release of information pertaining to my participation in ADAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in ADAP for the purpose of payment and to the organization(s) associated with the referring physician, and/or case manager indicated on the this page. By my signature below as parent, guardian or client, I request that payment of Medicare/Medicaid or other third party insurance benefits be made on my behalf to the South Carolina Department of Health and Environmental Control for any services, including STD and/or HIV, provided to me. Permission is also granted to DHEC to exchange the medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents or other agents needed to determine these benefits for related services. If applicable, I certify that information provided regarding the number of household members, family income and insurance benefits is true and correct to the best of my knowledge.***

_____ _____
Applicant's Signature **Date** **Referring Physician or Case Manager** (Print Name)

_____ _____
Referring Physician or Case Manager's Signature **Date** **Organization** (Print Name)

To be completed by the Physician or Case Manager:

The **most recent** CD4 (T4) lymphocyte count was _____ on _____ (date drawn). The **most recent** viral load result (if available) was _____ on _____ (date drawn).

Have you discussed with this patient the importance of adherence with the medications? ☐ ***Yes*** ☐ ***No***

Dear ADAP Insurance Patient:

This is a new enrollment form.

You must complete and return this form within 90 days to remain enrolled in this program.

You must take this to your case manager or doctor for their help in completing this form. Their signature is required to complete this form.

ALL SECTIONS MUST BE COMPLETED, *but fill out the "Assets" section only if you are enrolled in the Continuation program* where ADAP reimburses your insurance premium.

The **Social and Financial Data** section is important and must be completed or the form will be returned to you for completion. Please tell us where you receive the money that you live on and also tell us if the amount that you put down is a weekly, monthly, or yearly amount. Please list all of your dependents in this section because this information may be useful in helping you to continue to qualify for this program. **You must include proof of your and your spouse's income with this recertification form**. This proof of income includes most recent; paycheck stubs, W2 forms, Federal Tax Return, Pensions, Unemployment Compensation statement, Social Security benefits, Alimony, Child Support, and Worker's Compensation. **If your or your spouse's income is zero, you will need to go to your local unemployment office and request a wage statement to verify zero income. Do Not Leave this Box Blank!!! You must provide the income paperwork with this recertification form to remain in the program.**

You are required to fill out this form in order to stay active on this program and continue to receive your medications. **Please fill it out and mail it back to me as soon as possible**.

If we do not have a current Recertification form, you **will** be closed from the program. We want you to stay healthy so **please call me if you have problems with this form or contact your case manager**.

You do not need to call to verify that I have received your form nor will you receive a follow-up call from me unless I have a question. If your form is not filled out completely, it will be returned to you.

Please complete and return this form as soon as possible to me in the Business Reply envelope provided.

Please call me at (803) 898-0214 or toll free at (877) 606-8498 if you have any questions.

Sincerely,

Patti Sullivan
Insurance Coordinator